held by an assistant above and below the lesion and the contents being pushed away, the injured part of the intestine, two and a half inches in length, together with a triangular segment of the mesentery, was resected, the ends sutured with Lembert's suture, the abdominal cavity carefully cleansed, and dressings applied. The case progressed to an uninterrupted recovery, with a healthy spontaneous evacuation of the bowels on the fifth day. The writer notes that shock after the cutting away of the dead bowel is one of the chief dangers of the operation, and recommends a hypodermic injection of brandy and morphine or ether, just before this part of the operation is reached, in order to counteract the shock.

He advises, in conclusion, in cases of strangulated hernia: (1). When the bowel has been out some hours, and when it has been constricted sufficiently to render its return to a healthy condition at all doubtful, that it should be resected at once, if the condition of the patient is such that he or she can withstand the shock of the operation. (2). If the condition of the patient is such as not to admit of immediate resection, he would advise that the bowel be incised and left in place without interfering with the stricture until such time as the condition of the patient will allow the more radical operation. (3). If the resection is to be made as a primary or secondary operation, he would advise that the abdomen be opened in the median line, as by so doing he believes that we enhance many times the chances of recovery of our patient, while we do not in the least add to the dangers of the operation.—*Jour. Am. Med. Assn.*, May 7, 1887.

XIII. Operation for Ventral Hernia. By J. Edwin Michael, M. D. (Baltimore). A woman, æt. 55, fell several years previously such a way as to be struck in the median line, half way between the umbilicus and the pubes, by the handle of a washtub, without breaking the skin, causing a rupture in the linea alba through which the intestine soon came to protrude, no peritonitis following the injury. The belly wall was full and fat, but through it could be recognized the opening, elliptical in shape with the long axis parallel to that of the abdomen, apparently about $2^1/_2$ inches long and presenting a firm, hard

and apparently cicatricial margin. Reposition of the guts was easily obtained on assuming the supine posture, but it was impossible to retain them in the abdominal cavity. Under antiseptic precautions the ring was exposed and its lips were drawn together by stout silver wire sutures, passed about three-fourths of an inch from the edges and a little less than half an inch part. No shock followed the operation, the patient making an excellent recovery and finding it necessary to wear a supporting bandage only a few months after the operation. He based his operation upon the fact that a firm cicatricial band of fibrous tissue is formed around foreign bodies lodged in the tissues of the body, and, although so far as he was aware, he was without precedent or authority in the operation, he had assumed that if he placed silver wires in the tissues in this manner, the fibrous tissue which would enclose them would be sufficient to close the hernial ring.—*American Surgical Association*, 1887.

EXTREMITIES.

I. The Treatment of Ruptured and Divided Tendons. By C. H. WILKIN, M. D. (New York). This paper presents a table of 32 hitherto unpublished cases, of which 28 were treated by suture, with good results in 22 and benefit in all. He considers the injury in two classes, simple and compound. While in the former almost all authorities seem to agree that rest and position are sufficient, yet it would seem that a better result and certainly closer apposition could be obtained by the use of the suture; of the propriety of the suture in the compound variety, there can be no question. The plan of treatment recommended, is first thorough cleansing of the part and irrigation of the sheath of the tendon with a 1–1,000 bichloride solution—except when the knee-joint is involved, when it shou.d be 1–5,000—by means of a small English catheter with a syringe attached, cocaine anæsthesia, and the use of silk-worm gut suture, two sutures being necessary in the average tendon, one being carried transversely through the tendon and the other antero-posteriorly.—*N. Y. Med. Rec.*, April 2, 1887.

II. Suture of the Divided Ends of a Ruptured Quadricips Extensor Tendon with Perfect Recovery. By CHARLES